STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345471	A. BUILDING ______ B. WING ______	C 01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	**2415 SANDY PORTER ROAD CHARLOTTE, NC 28273**

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F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to code the minimum data set to	F 278	The statements included are not an admission and do not constitute	2/8/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 01/27/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 278	Continued From page 1 accuratelty reflect a resident's bowel continence for 1 of 3 residents sampled for ostomy care (Resident #1). The findings included: Resident #1 was admitted to the facility on 11/18/16 with diagnoses that included hemiplegia, multiple fractures of the tibia and cervical vertebra, carcinoma of the trachea, acute respiratory failure, and others. Resident #1 was discharged from the facility on 12/20/16. Review of Resident #1's medical record from 11/18/16 to 12/20/16 revealed no record of rectal tube or colostomy. Review of a nurse's note dated 11/23/16 at 5:03 PM read in part, large bowel movement (BM) noted. Signed by Nurse #1. Review of the most recent comprehensive Minimum Data Set (MDS) dated 11/25/16 revealed that Resident #1 was cognitively intact and required extensive assistance of one staff member for toileting. Resident #1's bowel continence was coded as "not rated" during the reference period of the MDS and constipation was noted. Interview with Nurse #1 on 01/11/17 at 3:00 PM revealed that she remembered Resident #1 very clearly. Nurse #1 stated that she did not specifically recall the large BM that Resident #1 had on 11/23/16 but stated he did not have a colostomy or rectal tube. Nurse #1 stated that when Resident #1 had a BM staff members would provide incontinent care and place a clean brief on Resident #1. Nurse #1 stated that Resident #1 had a feeding tube and had regular frequent BM's that required frequent incontinent care by the direct care staff. Interview with the MDS Coordinator #1 on 01/11/17 at 4:20 PM revealed that when a MDS was coded as "not rated" for bowel continence it	F 278	agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F278 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #1 was discharged from the facility 12/20/16 as Discharge Return Anticipated. To date, resident has not been readmitted to the facility. F278 How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: All current residents□ MDS will be reviewed to ensure Section H, question H0400 Bowel Continence, is correctly coded according to the documentation from the residents□ medical records. Any issues identified as being coded incorrectly, will be modified by the MDSC. Completion date: February 8, 2017 F278 Measures to be put in place or systemic changes made to ensure practice will not re-occur: Education was provided to MDSC by the MDSC regional consultant on January 17, 2017 on the	

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F 278	Continued From page 2 meant that the resident had a rectal tube or a colostomy. MDS Coordinator #1 stated that she did not complete Resident #1's MDS on 11/25/16 the MDS Coordinator #2 had completed it and she was fairly new to the facility and was new to completing MDS's. MDS Coordinator #1 did state that it appeared there was no information available during the reference period on Resident #1's bowel continence and that may have been why MDS Coordinator #2 coded it as "not rated." Interview with the Director of Nursing (DON) on 01/11/17 at 5:00 PM revealed that she expected MDS Coordinator #2 to review the entire medical record including nurse's notes and talk to the direct care staff to have the accurate information needed to code the MDS. The DON stated that this was MDS Coordinator's #2 first job working with MDS's and she was not sure the MDS was inaccurate but she felt like MDS Coordinator #2 had done the best she could with limited knowledge that she had. The DON also stated that MDS Coordinator #1 and the corporate MDS nurse had provided the training for MDS coordinator #2 and the over sight that was required for someone who was new to completing MDS. The DON further stated that she fully expected the MDS's to be coded accurately to reflect the patient's status. Interview with the Administrator on 01/11/17 at 5:44 PM revealed that he also fully expected MDS's to be coded accurately to reflect the patient's status. Interview with the MDS Coordinator #2 on 01/11/17 at 6:00 PM revealed that she was new to the position, she had just started at the end of September 2016. MDS Coordinator #2 revealed that the Corporate MDS nurse had provided her the training that she required in "bits and pieces." MDS Coordinator #2 stated that Resident #1 did	F 278	RAI requirements for coding H0400 Bowel Continence in section H. All new MDSC employees will be educated on proper coding of Section H, question H0400, according to the RAI Manual. The MDS Consultant or designee will audit 5 residents□ MDS to ensure Question H0400 Bowel Continence is correctly coded according to the documentation from the residents□ medical records once weekly for 4 weeks, twice a month for one month, and monthly x 10 months. Any coding issue identified on the audits will be immediately corrected with coaching/discipline as needed to the MDSC. Completion date: February 8, 2017 F278 How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the weekly audits will be reviewed at Weekly Risk Quality Assurance Meeting and Quarterly Quality Assurance meeting X 4 for further resolution if needed. Completion date: February 8, 2017	

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F 278	Continued From page 3 not have a colostomy so she coded "not rated" because there was no Nursing Assistant (NA) documentation to tell her if Resident #1 was continent or incontinent. MDS Coordinator #2 stated that she did review the progress notes but could not specifically recall if she had seen the large BM that was documented on 11/23/16, she also stated that the note did not indicate if Resident #1 was incontinent or continent. MDS Coordinator #2 also stated that without reviewing her notes she could not say if she had interviewed the direct care staff to find out the status of Resident #1's bowel continence.	F 278		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality	F 520		2/8/17

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F 520	Continued From page 4 assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in August 2016. This was for one recited deficiency that was originally cited in August 2016 on a recertification survey and subsequently recited in January 2017 on a complaint investigation. The deficiency was in the area of resident assessment. They continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The Findings included: This tag is cross referenced to: F278 Resident Assessment: Based on staff interviews and medical record review, the facility failed to accurately assess a stage 4 left heel pressure ulcer on an admission Minimum Data Set (MDS) for 1 of 3 sampled residents reviewed	F 520	F520 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: F 278 Resident #1 was discharged from the facility 12/20/16 as Discharge Return Anticipated. To date, resident has not been readmitted to the facility. F520 How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Individual actions denoted on said area for citation F-278. Completion date: February 8, 2017 F520 Measures to be put in place or systemic changes made to ensure practice will not re-occur: F278 Education was provided to MDSC by the	

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F 520	Continued From page 5 with pressure ulcers (Resident #96). During the complaint investigation of 01/11/17 the facility was cited for failure to code the minimum data set to accurately reflect a resident's bowel continence for 1 of 3 residents sampled for ostomy care (Resident #1). During an interview on 01/11/17 at 5:44 PM with the Administrator and the Director of Nursing, the DON stated the quality assurance (QA) committee met quarterly and consisted of the Administrator, DON, Medical Director, Nurse Practitioner, and all of the department heads. The DON reported that after the facility was cited for inaccurate MDS's in August of 2016 the corporate MDS nurse performed weekly audits and ongoing training. The administrator stated that part of the plan of correction was, they hired a second MDS nurse and they believed that would help with the caseload and the overall accuracy of the MDS assessments. The DON stated that the corporate MDS nurse was responsible for all the training of the new MDS nurse and he monitored her work and if he found any issues he would work with her to correct the issue. The DON further stated the corporate MDS nurse usually came to the facility once a month but maybe he could have more of a presence in the facility and that would help. The DON also stated that they definitely needed to do a better job of monitoring the MDS's and the new MDS Coordinator #2 would need some additional training.	F 520	MDSC regional consultant on January 17, 2017 on the RAI requirements for coding H0400 Bowel Continence in section H. All new MDSC employees will be educated on proper coding of Section H, question H0400, according to the RAI Manual. The MDS Consultant or designee will audit 5 residents MDS to ensure Question H0400 Bowel Continence is correctly coded according to the documentation from the residents medical records once weekly for 4 weeks, twice a month for one month, and monthly x 10 months. Any coding issue identified on the audits will be immediately corrected with coaching/discipline as needed to the MDSC. Completion date: February 8, 2017 F520 How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the weekly audits will be reviewed at Weekly Risk Meeting and Quarterly Quality Assurance meeting X 4 for further resolution if needed. Completion date February 8, 2017	